

S. No. 2
FORM-2-43
5-17-39
X35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **8636**

FILED OCT 13 1943 **818**
Registration District No. _____

Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **8 Days**
In this community **39yrs.** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **17**
(c) City or town **St. Louis** **925**
(If outside city or town limits, write "RURAL")
(d) Street No. **911 Market St.,**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Thomas Campbell**

3. (b) If veteran, name war **Unknown**
3. (c) Social Security No. **Unknown**

4. Sex **Male**
5. Color or race **White**
6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife **Single**
6. (c) Age of husband or wife if alive **Single** years

7. Birth date of deceased **February 29, 1861**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 6 2 hr. min.

9. Birthplace **Dover New Hampshire**
(City, town, or county) (State or foreign country)

10. Usual occupation **Nil.**

11. Industry or business **Nil.**

12. Name **Alex Campbell** **New Hampshire**
13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name **Linda Williamson**
15. Birthplace **New Hampshire**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ann Morrison**
(b) Address **St. Louis City Hospital**

17. **Autopsy Board** Date thereof **9/4/43**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Louis**

18. (a) Signature of funeral director **[Signature]**
(b) Address **3500 Kentucky**

19. (a) **SEP 30 1943**
(Date received local health officer's certificate) (b) **[Signature]**
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **31**, year **1943** hour **4:40** minute **A.** M.

21. I hereby certify that I attended the deceased from **August 24**, 19**43** to **August 31**, 19**43** that I last saw him alive on **August 31**, 19**43** and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive heart disease**

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) **[Signature]**

Major findings: Of operations **none**
Of autopsy **none**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury **[Signature]**

23. Signature **[Signature]**
Address **1515 Lafayette Avenue** Date signed **8/31/43**

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.